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network

SMMGP SUBSTANCE MISUSE MANAGEMENT IN GENERAL PRACTICE

A national newsletter on substance misuse management in primary care

NTORS – Choose maintenance or detoxification – not 'reduction'

The patients who sought treatment in the NTORS methadone programmes presented with a range of serious and chronic drug misuse and other problems (Gossop et al., 2000). The most frequently reported drug problem involved dependence upon heroin, though the majority of patients were multiple drug misusers. After starting methadone treatment, the NTORS results showed a range of substantial reductions in problem behaviours. These were clearly shown in terms of reductions in use of heroin, non-prescribed methadone, and benzodiazepines, reduced injecting and sharing of injecting equipment, improvements in psychological health, and reductions in crime.

The prescribing of gradually reducing doses of methadone is one of the most widely used treatments in the UK. NTORS found several differences between methadone maintenance (MMT) and methadone reduction (MRT) programmes. **The patients in MRT were more likely to receive low doses and had poorer retention rates** (Gossop et al., 2001). Treatment retention has been found to be one of the most consistent predictors of favourable treatment outcomes. We also found that reduction programmes were frequently not delivered as intended. Whereas the majority (70%) of the patients allocated to maintenance on an intention-to-treat basis received methadone maintenance, only about a third (36%) of the patients allocated to MRT received reduction. Many patients who failed to receive MRT as intended appeared to have received some form of maintenance (Gossop et al., 2001). The failure of almost two thirds of the MRT patients to receive reduction treatment as intended raises a number of questions for treatment providers and policy makers. If most of the patients for whom MRT is planned and started, subsequently have this treatment changed, this calls into question the appropriateness of either the initial treatment planning process or the treatment delivery process, or both. **More troubling was the finding that where MRT was delivered as intended, it was associated with worse outcomes.**

Several factors were found to lead to improved outcomes. These included the provision of services in addition to the administration of methadone. The frequency and content of counselling sessions, for example, was found to have both direct and indirect relationships with improved heroin use outcomes. We also found a direct inverse relationship between methadone dose and frequency of heroin use at 1 month follow-up. Although methadone dose was not directly related to 6 month heroin use outcomes, its indirect influence was reflected through the strong positive association between frequency of heroin use at 1 month and at 6 months. This is consistent with the results from other studies which suggest that events occurring very early in treatment can have an effect upon later outcomes. The clients' perceptions of, and engagement with programmes were found to be related to reduced frequency of heroin use outcomes. An important task of treatment should be to increase motivation and engagement of patients.

Two areas in which substance use outcomes gave rise to concern involved crack cocaine and alcohol. Although the majority of NTORS patients were primarily dependent upon heroin, a substantial minority (about one third) were also using crack at intake. In the NTORS sample, although there were increases both in the rates of abstinence from crack and reductions in the frequency of use between intake and 1 year, these improvements appeared to gradually dissipate over time. For example, by the time of the final (4-5 year) follow-up, the overall rates for crack use and the frequency of use had returned to about intake levels among the methadone patients. This result disguises different patterns of crack use among those who were using crack and those who were not using crack during the period prior to intake. Among those who were using crack at intake, levels of use were more than halved at all follow-up points. In contrast, among those who were not using crack at intake, there was a gradual increase in the use of this drug. For this reason, our results regarding use of crack cocaine should be interpreted not as indicating a tendency to relapse to pre-admission patterns among those who were already using this drug at intake, but as being largely driven by the initiation of crack use among those who were not using crack at intake.

For alcohol consumption, the outcomes were not satisfactory. At intake, a substantial minority of the methadone patients were drinking excessively. No change was found at any point during the follow-up period. Alcohol is an important but neglected component within of the substance use problems of drug misusers in treatment services. Chronic alcohol abuse is an important cause of medical complications among drug misusers, and alcohol use is linked to increased risk of overdose and mortality (Gossop et al., 2002). The poor drinking outcomes among the methadone patients is a matter which requires urgent attention by methadone treatment services.

Professor Michael Gossop, National Addiction Centre, The Maudsley/Institute of Psychiatry, London SE5 8AF.

See article and full references at www.smmgp.co.uk

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Consultation and user representation - designing services users want

Users are the ultimate consumers of drug treatment services but 80% of problematic drug users fail to access treatment

Sandy O'Neill, General Manager The National Drug Users Development Agency (NDUDA)

Consultation and user representation means involving users in the process of designing services that meet their needs. The benefits of user involvement and consultation include the provision of constructive involvement in the provision of services which users want; advocacy in the use of health and social services; user self-help & mutual support; dissemination of harm reduction messages through peer networks; and 'Intelligence' on new drug trends or problems.

There are two types of user consultation:

1. Service user consultation improves relationships between drug services and their clients. It provides an opportunity to bring drug users within NHS modernisation agenda for users and carers but restricts audiences and risks services defining terms of engagement. The Alliance is an example of a drug user led organisation whose primary aim is improving services.

2. Drug user consultation includes drug users who don't feel services are designed for them. It provides opportunity to address wider issues of social inclusion and includes groups of users services fail to attract and allows ex, current and prescribed drug users to work together and support each other. The risk is that social agenda is misconstrued as political agenda. The NDUDA is an example whose primary aim is empowering users to address the wider issues.

Barriers to meaningful consultation include a lack of open management and users consultation feeling "flavour of the day" or a "tack on" to attract funding. There can be a perceived lack of fairness between funding for professional user involvement workers while drug user self-organisations are left struggling with inadequate resources and expected to offer time on voluntary basis. Professionals are often seen as controlling the agenda. Where users feel tied to an agency agenda, they feel they can only contribute to the benefit of the agency staff as opposed to the benefits for users. Users often feel unable to criticise or challenge for fear that they may be subject to sanctions. This can be compounded by the adversarial nature of some drug services. A leap of faith is required in acknowledging that users views are valid. 'Many users have trust issues with professionals. When things go wrong, or the results of the consultation process never see the light of day, then this further distances users from professionals; feeling that consultation is nothing more than an exercise in box ticking leading to reluctance to get involved again.

'Many sponsors would be more likely to support the right of the constituent group if such autonomy did not pose a threat to their own survival and developmental needs' Brager et al (1986) 'Community Organising'

There are two different possible outcomes of user consultation:

1.Ticking boxes or tokenistic. This is participation without power that leaves drug users feeling even more excluded. Users become disillusioned, walk away or relationships fragment. This is being ***done to*** - feels just like many experiences of 'treatment'.

2.Transforming service relationships or genuine. This is an open process and mature commitment by users and professionals to work together. This is more like ***done with*** - what treatment relationships should be like

Mechanisms to increase user consultation include: methods to gaining informal comments such as a comments /suggestions box; or more formal user complaints procedures; satisfaction surveys; management committee places; an open management and staff culture that encourages agency service user groups to 'feed' their views upwards; places on DAT commissioning teams. Methods to include user groups who are not accessing services can include involvement in resource production (writing/designing leaflets/websites) and involvement in development and review processes. Approaches to removing the barriers can include giving incentives or payments that demonstrate value for users contribution to the consultation process. Regular feedback or progress reports that show what changes are taking place as a result of the consultation are invaluable.

Professional services need to redefine their relationships with users and manage this transition with care and sensitivity. Recognising the need to reconcile difficult and often conflict based issues. Recognising that the invitation to be consulted on their services, is for many users, the first opportunity for rebuilding trust! Effective consultation works when the barriers are removed and Users can see change happening and how they and other users have contributed. User self esteem improves as a result as they feel 'involved' and valued rather than passive recipients.

The National Drug Users Development Agency is run by and for drug users whose member groups include a wide range of drug groups working in local areas and in the national arena. It facilitates representation at national and regional level supporting information sharing, consultation and engagement of wider services through use of the population and the drug using community as a whole. It aims to support and facilitate best practice of drug user self-organisation in all its forms. It is available to local services or Drug Action Teams on a paid consultancy basis. **Contact Sandy O'Neill** sandy.nduda@btconnect.com **020 7739 6633**

The Alliance is a user-led organisation, supporting people receiving treatment for drug dependency. Service users and professionals work together as equals creating a unique initiative to give service users a real voice in the treatment debate. We actively encourage the involvement of service users in every stage of our work. **Contact Bill Nelles** billnelles@blueyonder.co.uk **020 8374 4395**

NB Editors Note: Many local services and some GP surgeries are now supporting the development of user groups. If there isn't a group in your area, then please ask users you see to contact either of the above organisations or make contact yourself.

BUPRENORPHINE IN PRIMARY CARE: SUMMARY

What is it, how to start it and how to use it

February 2003

- Buprenorphine *(Subutex)* can be a useful alternative in the treatment of opioid dependence either for detoxification or maintenance purposes.
- Comes in 8mgs, 2mgs and 0.4mgs tablets which need to be taken sub-lingually (dissolved under tongue) as swallowing inactivates the drug properties
- Most suitable for use in primary care for those patients who are opioid dependent and are on either heroin or less than 30mg of methadone (or can reduce to this level)
- Direct equivalence between buprenorphine and methadone is difficult to estimate and it is not a linear relationship, 12 to 16 mg buprenorphine is approximately as effective as 50 to 80mg methadone in reducing heroin use and retaining patients in treatment.
- Like methadone, buprenorphine interacts with other central nervous system depressants including benzodiazepines, antidepressants and alcohol
- Advantages of buprenorphine compared to methadone:
  1. Less dangerous in overdose
  2. With maintenance doses between 8-32mgs the effects of other opioids used 'on top' are markedly reduced, maximal effect between 12 to 24 mg daily
  3. Useful in maintenance and detoxification, reported as easier to withdraw from
  4. Clearer head on medication, less 'clouding' effect
- Disadvantages of buprenorphine:
  1. Highly soluble leading to potential for injection
  2. Can precipitate acute opiate withdrawal if used incorrectly
  3. Less 'opiate-like' or 'clouding' effect
  4. More expensive than methadone
- Starting buprenorphine
  - » Carried out by dose induction in a similar way to methadone induction, but this can be undertaken much more rapidly (i.e. over a few days).
  - » Generally advised to start at 4mgs a day and increase by 4mgs daily until stabilised, to a maximum of 32mg per day. Commonly settle for maintenance between 12-24mgs.
  - » Initiate buprenorphine at least 8 hours after the last dose of heroin, and between 24 - 36 hours after the last dose of methadone and with the first signs of withdrawal to prevent precipitated withdrawal.
  - » Asking the patient to wait as long as possible (so the previously taken opiates have been metabolised) before taking the first dose helps the induction.
  - » Always give full explanation of the drug and its effects to the patient.
  - » Explain the first 3 days may experience some unpleasant effects such as restlessness, insomnia and diarrhoea. Lofexidine may be helpful with these unpleasant effects.
  - » Those on more than 30mg methadone per day will need to reduce to 30mg or be transferred to a specialist for transfer.
- The most commonly effective maintenance dose is between 12 – 24 mgs per day, but lower or higher doses (maximum 32mgs) may be used
- Buprenorphine detoxification may be carried out using rapid or gradual regimes according to the needs of the patient
- Instalment prescribing can be written on FP10(MDA) in England and Wales or HBP(2) in Scotland

Buprenorphine is a useful alternative for opioid dependent people. It widens the choice for opiate users who do not want methadone or who are intolerant to it. It is a useful addition for substitute medication, but not if the patient is stabilised and doing well on methadone and may be considered as a first choice for people dependent on opioids who wish to become opiate free.

See full RCGP/SMMGP buprenorphine guidance at
www.smmgp.demon.co.uk/download/articles/art016.pdf

Viewpoint –

Accepting reality - the GP and the criminal justice system

The updated drugs strategy continues to place an emphasis on breaking the link between drugs and crime. Dr Linda Harris reviews the evidence and argues the case for the need to develop innovative partnerships with the criminal justice system

The introduction of the 1999 Clinical Guidelines and the Government's ten-year strategy has shifted the public health message from an emphasis on harm reduction and maintenance of health status to more of one of social control and crime reduction. For some GPs this is fundamental worry. Drug Treatment and Testing Orders (DTTOs) have now become an established community sentence and the government has set a target of an increase in completed orders by 50% from April 2003. This is against a backdrop of planned mergers between Drug Action teams and Crime Reduction Partnerships. Police and probation, already contribute to the pooled treatment budget and therefore have responsibility and a vested interest in the performance and efficacy of local arrest referral and DTTO schemes. For the first time this year new monies from criminal justice agencies will feed directly into the pooled budget enabling treatment providers to expand criminal justice treatment programmes in line with the revised targets in the government's updated drugs strategy. Clinicians are tasked with ensuring that there is equity between coercive and non coercive treatment services in terms of access, choice and quality, a challenge that is becoming increasingly difficult as resources focus more and more on breaking the drug-crime link and reducing recidivism.

Over the years Wakefield has gained a reputation for good partnership working with the criminal justice system. West Yorkshire was the professional homeland of Keith Hellawell, the ill-fated Drugs Tsar and the Wakefield STEP Project, based on the Miami Drug Court model was granted "Beacon" status superseding DTTOs and using the flexibilities of the 1A6 probation order to effect change. The 1A6 came with conditions of treatment but it did not stipulate the hours of contact in treatment or that testing HAD to be part of the order. The Wakefield Substance Misuse Strategy endorses the expansion of partnerships between drug treatment services and criminal justice and we have recently secured funding for a six-month pilot scheme targeting prolific shop thieves. The funding will be used to expand our arrest referral team and covers the provision of additional police hours to enable them to outreach into the community. The police will be working with clients known to be committing crimes to fund their habit but who have yet to be charged for such offences. If the client is agreeable and deemed willing to engage with services, the police will liase with a dedicated treatment worker and actually transport the clients to their assessment appointment. Clients who fail to engage with treatment services in accordance with the *Community Drugwatch* treatment contract will be discharged from the treatment clinic and the police officers involved will be informed. Clients will be signposted towards the nearest community treatment team where they will be able to join the waiting list if they so wish

Benefits - Local police intelligence indicates that many users fund their habit through retail crime and whilst many such individuals manage to avoid arrest, it is a matter of time before they are caught and held up before the courts. In the meantime they continue to participate in daily criminal activity with negative effects on public safety, family harmony and the local economy. If the project is successful there is a potential "win-win" situation for retailers and therefore we are looking for commitment from local stores to subsidise the scheme in order to secure its future. Ownership of schemes such as this by police, retail outlets and treatment providers illustrate the need to for a shared responsibility of society's drug problems and also feed into government strategies such Neighbourhood Renewal.

Constraints - In common with other schemes that fast track clients committing crime over more "law abiding" users, this project is open to criticism. Fast-tracking clients indirectly relieves pressure on waiting times for non-coercive treatment programmes but the survival of scheme's such as this is highly dependent on good outcome data such that strict entry criteria will have to be applied. This means the inevitable targeting of only those clients who are highly motivated and willing to enter a detoxification programme overlooking once again, those clients with more complex needs where a harm reduction approach with a focus on health needs is more suited

A happy marriage between health and criminal justice? It is fair to say that the UK experience of coercive treatment has concentrated on reductions in acquisitive crime and drug-spend. A doctor's role is fundamentally about improving health, which makes a transition into coercive work problematic in terms of role and doctor patient relationship. Many senior police officers wish to see a blurring of the boundaries between community safety and client care and whilst it is laudable to seek to break cycles of crime and split the vulnerable from the organised criminal their desire to gain "intelligence" from such clients could create a controversial situation for the treatment providers working closely with them. As yet there appears to have been no exploration of the possible impact of coercion on the doctor patient relationship and indeed whether or not this change has had any effect either positively or negatively on psychosocial treatment outcomes. **Increasingly GPs are extending their role and becoming commissioners and managers of services, a role that demands securing the maximum funding for their services including funding from the CJS.**

Despite this the message from Government leads us to speculate on a future for primary care treatment providers where social policy and reform depends increasingly on marriages between health and criminal justice and where providers must capitalise on any new investments regardless of source and develop services that meet the government's strategic targets. Debates around the potential threats (and opportunities) of a marriage between health and criminal justice have so far failed to consider their implications for healthcare professionals and patients. Whilst interventions aimed at breaking the drug crime link continue to be attractive to commissioners there has been a disproportionate investment in research and evaluation that will produce the evidence base to support criminal justice partnership models over harm reduction.

My personal experience of initiatives that aim to break the drug crime link is one of the positive benefits of partnership working, namely a greater understanding of each other's roles and responsibilities in the prevention and treatment of drug misuse. Criminal justice research outcomes demonstrate improved efficacy but perhaps we will only be in a position to silence the critics when we have well-designed and randomised controlled studies focussing on psychosocial outcomes delivered in a

criminal justice framework. Maintaining the integrity of our "health role" is challenging given the realities of commissioning, planning and providing care within the framework of the Government's ten-year strategy. Models of Care – widely supported by the treatment community draws on key policy documents, which include those focussing on the criminal Justice system. We must all be "compliant" with Models of Care and will be performance monitored accordingly. Perhaps the missing link is the piece of research or audit that demonstrates the added value in terms of bio-psychosocial milestones of the treatment interventions delivered in partnership with the Criminal Justice agencies. **Dr Linda Harris, Clinical Director, Wakefield Integrated Substance Misuse Services (WISMiS), Grosvenor House, 8 – 20 Union Street, Wakefield, WF1 3AE**

What makes for good pharmacy involvement?

I am a locum pharmacist and also a researcher. I have worked in a specialist drugs agency and have locumed in many pharmacies that provide both needle exchange and dispensing for drug users. I work with drug users for many reasons. Professionally I consider I have a duty of care to all members of the public and cannot discriminate between who 'deserves' and who doesn't. I can back this up with the first principle of our code of ethics which states that my prime concern must be for the welfare of the patient and the public. Providing services to drug users benefits both the patient and the public enormously. There is a huge and very strong evidence base for both needle exchange and maintenance therapy, in terms of promoting health and, in the case of maintenance, reducing drug related crime. Few other healthcare interventions can produce such dramatic and wide-reaching results. Working with drug users is incredibly rewarding and fair to say relatively easy. Community pharmacists don't really get such close contact and ongoing follow-up with any other patient group. We tend to see people sporadically and never really get the luxury of knowing the outcomes from our advice or interventions. Working with drug users is different, often we see them every day. We see people become healthier as they continue on maintenance treatment. Over time, a rapport develops between yourself and the drug user, which allows you privileged insight into the life and well being of the individual. The difference that maintenance treatment makes to the lives not only of the drug user, but their families too, becomes very apparent and it is truly rewarding to know that you have been part of that process.

Community pharmacists often struggle with working in isolation and complain about a lack of professional respect from GPs. In my experience, working with drug users brings you closer to GPs, allowing you to share your professional experience and advising each other on a level playing field. Clinically, it is not generally a complex area to work in and with a sound knowledge of pharmacology and therapeutics, it is an area where the pharmacist's expertise can be of great value to the prescribing team and the client – for example advising on over-the-counter medicines which may give false positive urine tests.

I particularly enjoy working with needle exchange clients. Often people who use pharmacy based needle exchanges are new injectors and people who don't access other services. This means that I might be the only healthcare professional that the client ever has contact with. This means my role in encouraging people to use specialist services and access treatment is key, as is my role in promoting responsible disposal and returns. It also means I have to be competent in providing safer injecting advice and injection site injury advice. Again this means undertaking Continuing Professional Development and developing good working relationships with specialist drugs services and A&E departments, so I don't send drug users for inappropriate or unwelcoming care.

Pharmacists are often scared of working with drug users, many may not have knowingly met a drug user before and all the stereotypes and scare mongering that we see in the media informs their views. Although I was worried before I started working in this area, in my experience few of these stereotypes are ever upheld. Drug users are in the main nice people who are usually very grateful for the services you provide. I have not experienced any difficulties that cannot be ironed out. The key is to treat drug users like any other pharmacy client, with respect and courtesy, which is almost always returned. When I left my last job I was overwhelmed by the cards, flowers and good wishes that my drug users gave to me. It is in my view the most rewarding area of pharmacy practice. **Jenny Scott**

Classics revisited

Heroin Addiction and Drug Policy, The British System

Strang, J and Gossop, M (ed)
Oxford Medical Press 1994

This classic text is a must for anyone who wants to understand the history and development of the British drug treatment system. The different aspects of an eclectic system of treatment provision are put into perspective by the leading authors in the field at the time. From a community prescribing perspective there is a very informative chapter by Bing Spear charting the history of prescribing policy. This describes how the activities of one doctor, Lady Frankau, almost single handedly persuaded the second Brain Committee to recommend that prescribing be taken out of the hands of GPs and that special clinics be set up run by psychiatrists with home office licenses (heroin was the main drug prescribed at that time). "The 'psychiatrizing' of addiction treatment policy in the UK was assured", he concludes.

In subsequent chapters the progress of these new clinics is charted as is the shift to oral methadone prescribing, often on a reducing basis, as psychotherapeutic interventions became preferred. The journey then takes us through the 1980's and the attempt to create a more community based approach with the advent of CDTs and their remit to re-engage GPs and other professionals in treatment. This largely failed as team members took on casework rather than facilitation. As a parallel story a chapter by Alan Glanz charts in detail 'The Fall and Rise of the General Practitioner' both in drug dependency treatment but in the context of a general fall and rise in the NHS.

The book generally gives the most comprehensive and authentic resume to date of the very unsystematic 'British System'. Fascinating for anyone interested in history but also essential for understanding the system within which we work.

Jim Barnard

Paper review

Gossop, M. et al. Factors associated with abstinence, lapse or relapse to heroin use after residential treatment: protective effect of coping responses.

***Addiction* 97; 1259–1267.**

This technical paper from the NTORS team investigates factors associated with abstinence, lapse or relapse to heroin use after residential treatment. Specifically, the extent to which changes in cognitive, avoidance and distraction coping responses were related to heroin use and other drug use outcomes. Data on client characteristics and problems, coping responses, drug use and other outcomes, were collected by structured face-to-face interviews. 242 clients from 15 residential rehabilitation programmes and 8 in-patient units in the NTORS project, who used heroin before treatment and who were followed-up after treatment during the first 12 months of the study.

- Many clients (60%) used heroin after treatment, with the first occasion of heroin use usually occurring very soon after leaving treatment: 40% remained abstinent from heroin.
- Clients who avoided a full relapse to heroin use (abstinent and lapse groups) consistently made more use of cognitive, avoidance and distraction coping strategies at follow-up than at intake.
- Treatment completion was related to better outcome.
- The lapse and relapse groups reported higher rates of use of illicit drugs other than heroin after treatment than the abstinent group.
- The heroin users who were facing pressures from the criminal justice system at intake to treatment were more likely to have worse heroin use outcomes at follow-up. Among the abstinent group, just over a quarter were facing legal pressure at admission, whereas more than a third of the lapse group and more than a half of the relapse group were under pressure.

C. Matherson, J. Pitcairn, C.M. Bond, E. Van Teijlingen & M. Ryan, General practice management of illicit drug users in Scotland: a national survey.

***Addiction* 2003; 98. 119-126.**

This is a cross- sectional randomised structured postal questionnaire survey. It aims to describe the level of involvement of general practitioners in the management of illicit drug dependency; the nature of current practice in the management of illicit drug dependency; the influence of guidelines on practice; GP training experience and needs; to consider the policy implications of the findings. It achieved 63% response rate with 60% of respondents treating drug users. 51.5% provided methadone maintenance but only 58% used doses in the recommended range. Maintenance prescribing of dihydrocodeine and benzodiazepines was provided by 24% and 44.8% of respondents respectively. 79.3% had received the national clinical guidelines, but only 22.5% believed this had influenced their practice. Only a third of respondents had received drug dependency training. Beliefs about drug dependency being part of a GP professional remit were split. Relatively high involvement with drug users with methadone maintenance was the most common treatment provided. Maintenance prescribing of dihydrocodeine and benzodiazepines were common despite a lack of clinical evidence supporting the effectiveness of these treatments. This possibly reflected the nature of presenting drug problems and highlighted the difficulties some GPs may face in the managing of multiple drug dependencies within current guidelines. Further local training to implement guidelines along with trials of alternative treatments currently outside of the Clinical Guidelines should be considered.

Dr Fixit - Alcohol relapse

Ted came to see me saying he had started to drink again after a party. He stated he had previously had "drink problem", but had not drunk for 9 months following a hospital detoxification and counselling. He had now been drinking again for the past 3 weeks, about half a bottle of whiskey (+/-15units) / day. He is very keen to stop and get back to work (he has been off for 3 weeks). He feels he does not need hospital treatment again but has felt unwell when he has tried to stop and wants me to prescribe something for him. He lives with his wife who is supportive. How should I proceed?

Reply by Dr Sally Read and Dr Chris Ford - The first things to do are the standards – take a history and do an examination. We need to find out about Ted's drinking history in more detail – for how long and how much had he been drinking in the past, had he had more detoxifications than the one you mention and if so, where had they taken place, how many times, and with what outcomes. Has he had any physical sequelae of his alcohol intake? – particularly relevant at this point are a history of withdrawal fits, liver disease or DTs. How has his mental health been and was the recent lapse secondary only to the temptation offered by the office party or have been there been other recent stresses in Ted's life? Although he appears committed I would like to assess this in more depth. We need to know something about his health over the last 3 weeks too – has he tried to stop himself and been unable? A physical examination should be undertaken with exclusion of jaundice, ascites or cardiac complications.

At some point during this first consultation, I would want to explore Ted's attitude to this " relapse". He may be feeling very guilty, with a profound sense of failure. I would try to refer to the last 3 weeks as a lapse, and explain that it should be possible to prevent this becoming a full-blown relapse. It is often possible to use a lapse following abstinence to look at triggers for drinking and devise avoidance strategies for the future.

Next we need to find out what Ted is expecting the 'something prescribed' to be. He has had some experience of detox in the past and may be quite knowledgeable. The main aims of prescribing in alcohol detox are symptomatic relief and prevention of withdrawal fits. These can be achieved by prescribing a reducing dose of chlordiazepoxide, over a 8-10 -day period. A possible regime would be:

Chlordiazepoxide 30mgs	**(*20mgs)**	**QDS for 2 days (*female dose)**
Chlordiazepoxide 20mgs	**(*15mgs)**	**QDS for 2 days**
Chlordiazepoxide 10mgs	**(*10mgs)**	**QDS for 2 days**
Chlordiazepoxide 5mgs	**(*5mgs)**	**QDS for 2 days – then stop**

- The dose level and length of detox will depend on the severity of the alcohol dependence.
- There needs to be some titration against the dose of alcohol the patient is using.
- The regime needs to fit to individual need and symptoms.
- Some patients need bigger doses

It is never acceptable to prescribe chlormethiazole (Heminevrin) to an outpatient, or as part of a community detox.

Vitamin deficiencies also need to be addressed and it is usual to also give thiamine although Ted is probable OK because of his short history.

Ted is complaining of symptoms so needs help with stopping safely. He has requested detox at home and this would be worth attempting. **He has insight, support from his wife and a job to go back to so is a good candidate for home detox.** He may need additional support and this can often be provided by a home detox nurse from the local alcohol service. Ted should be advised that the first 2-3 days will be the most uncomfortable. He should be advised that he may feel thirsty and will probably have difficulty in sleeping, but that these symptoms will resolve. After 8-10 days, the worst of Ted's withdrawal symptoms should be over and he will be able to stop his chlordiazepoxide. He may still be sleeping poorly, however, and needs to be reassured that this is normal and may take up to 3 months to resolve. I often prescribe amitriptylline at this point, if simple sleep hygiene measures are not working. It is important to avoid benzodiazepines and zopiclone.

Once through his detox, Ted is going to need ongoing support and relapse prevention. You can do some of this work but try to engage him with an alcohol counsellor or addictions therapist, who can help Ted explore the triggers to his drinking and adopt avoidance strategies. Some alcohol-dependent patients find support from Alcoholics Anonymous, which is a self-help group . Ted's wife may find Families Anonymous for friends and family of alcohol users useful. Psychosocial support may be accompanied by prescribing aimed at preventing a return to drinking. Two agents are available: disulfiram (Antabuse) and acamprosate (Campral). See box below.

In summary, Ted should do well – he is motivated, with a short history, a previous period of not drinking and he has support. If he didn't have these, then it would be important to look for in-patient detox. Don't forget that the detox is a stage and not an endpoint. It is essential that any approach to alcohol dependency should involve holistic psychosocial intervention.

Acamprosate (Campral EC)

- Can be useful in the maintenance of abstinence, in conjunction with counselling
- Relapses have been shown to be less frequent over the first year when acamprosate is prescribed in combination with counselling.
- It should be taken with meals and commence treatment immediately after alcohol withdrawal and continue for one year.
- **The dosage is:**

for patients 60kgs and over	=	666mgs tds
for patients less than 60kgs	=	666mgs am, 333mgs at midday and night

Disulfiram 200mgs (Antabuse)

- Can be used after a patient has undergone detox and wishes support in remaining alcohol free.
- Should only be initiated following a through assessment and requires careful monitoring.
- Alcohol should not have been consumed for at least 24 hours before treatment
- Normal dosage is 200mgs daily, sometimes a larger dose is given for the first few days but this is not necessary and can lead to increased side-effects.
- If people are drinking on 200mgs of disulfirsm, it should be increased in 100mgs stages before writing it off as a failure.
- The disulifiram reaction includes flushing of the face, severe headaches, palpitations, tachycardia, nausea, vomiting and with large amounts of alcohol arrhythmia's, hypotension and collapse.
- **Contra-indications: cardiac failure, history of CVA, hypertension, psychosis, severe personality disorder, suicide risk, pregnancy.**

Dr Fixit - Buprenorphine for detox

see buprenorphine guidance on www.smmgp.demon.co.uk/download/articles/art016.pdf

John who is 22 years old has been using drugs, mainly heroin since he was 17. He also drank 20-30 units per week, took crack up to twice a week and non-prescribed diazepam when available. He first presented to me aged 19 years and always wanted to become drug free. I have been treating him from the beginning and he has attempted two community detoxes with methadone and two hospital detoxes with lofexidine, but he relapsed onto heroin before completion on each occasion. He had been on methadone maintenance for 6 months and has now again chosen to be on reduction. He had always resisted the option of residential rehabilitation but now wants to go and wants to detox prior to going. He is currently on 30 mg of methadone, he is not using on top and his urine is negative for all except methadone. I would like to use buprenorphine but I have not prescribed it before. How would I proceed?

Reply by Dr Chris Ford & Dr Nick Lintzeris

Buprenorphine is potentially a good choice for John as many patients describe a milder withdrawal process when reducing buprenorphine than with methadone - given that he has had difficulties reducing off methadone in the past. He and you have got to a good point to transfer to buprenorphine. Transferring from 30mg methadone is rarely a problem. People get anxious about starting something new so explain the drug fully to him (and a carer if possible). Emphasise possible transient side effects (e.g. headache, nausea, disturbed sleep, metallic taste) and the need and reasons for taking the medication sublingually (lower bioavailability if taken orally). Explain the likelihood that it may take a few days for him to feel comfortable on buprenorphine. To start him off, stop the methadone and ask him to wait at least 24hrs until he is experiencing mild withdrawals. The longer he waits the easier it is. Ask him to take 4mgs (2 X 2mgs tablets) of buprenorphine sublingually and review him after 24 hrs. Increase the daily dose to 6 or 8 mg, with subsequent dose increases if required (patients transferring from 30mg methadone rarely need more than 12mg buprenorphine). Stabilise him on that dose for a few days then reduce by 2mg/week until 2mg is reached. This reduction can be made faster or slower depending on the patient. At 2mg change to 0.4mg tablets and give x3 (1.2mg) for a week, x2 (0.8mg) for a further week and x1 (0.4mg) for one week. Try and arrange for this final week to be undertaken just before (or in) rehab so he is not vulnerable in the community. Most patients will describe only mild withdrawal discomfort when stopping buprenorphine using such a slow reduction regime, although some patients may complain of sufficient withdrawal discomfort to warrant symptomatic medication for a few days (e.g. lofexidine). Be prepared to see him at any time and don't forget to give him a patient leaflet. See www.smmgp.co.uk in 'articles'

Call for papers *for primary care peer review journal* - special edition

SMMGP is planning a special edition "pilot" peer-reviewed journal addressing issues of substance use in primary care. This edition will inform the feasibility of a future journal and we are asking you to be part of this process. If you have, or are willing, to write a cross-referenced original research paper, a discussion paper or a review article of up to 4000 words then we would like to hear from you. Write or email with your topic and when you would be able to submit a final draft. Deadlines for final submission are end October 2003. Expected publication is Spring 2004. And for those academics amongst you, remember that acceptance of a peer-reviewed article can be cited on your CV! Contact nat.wright@virgin.net or PCNet@smmgp.demon.co.uk

Bulletin Board

Crack - On the Rocks This excellent study is of 100 crack users going through a London based treatment service. It gives a valuable insight into the lifestyle of crack users as well as the problems associated with crack. It also demonstrates that treatment can be effective, with weekly drug spending among the group falling dramatically (£ 800 -£80 after 18 months). Complete abstinence among the group, however, was rare. Gaps in service provision were identified such as low-threshold services and aftercare. Interviews with the large number of respondents from black and minority ethnic groups identified the lack of appropriate provision for them by traditional drug services. The study was conducted by the Criminal Policy Research Unit at South Bank University, in partnership with City Roads (crisis intervention) Ltd. Read the full report at www.sbu.ac.uk/cpru/publications/Rocks.pdf

Rate of GP involvement in treatment rises again. According to preliminary analysis of the DAT treatment plan returns for 2002/3 (in reality reflecting figures from the end of 2002) the rate of GP involvement in 'shared care' nationally now stands at 23% up from 19% in last years returns. This figure does not include GPs treating drug users in isolation. This figure hides huge regional (range 13% to 39%) and local (range 0%-100%) variations. However a 20% rise in a year is quite impressive. Final analysis will be published on the NTA web-site www.nta.nhs.uk

Conference - Still Working with Substance Misusers in Primary Care - Where to Next? Friday October 17th 2003 at the GMB National College, Whalley Range, Manchester Cost is £100 including lunch, refreshments and a post conference pack. Speakers are Dr Tom Carnwath, Consultant Psychiatrist, on Heroin Prescribing; Dr Kevin Heggarty, G.P, Engaging G.Ps; Dr Nick Lintzeris, Honorary Lecturer, How to Prescribe Buprenorphine; Annette Dale-Perera, National Treatment Agency, Models of Care Update; Christina McArthur, SMMGP, SMMGP Update; Dawn Harvey, Domestic Violence. Workshops include Hepatitis C – Dr Chris Ford; Amphetamines and Crack – Aiden Gray and Grantley Haynes; Dual Diagnosis – Mark Holland; Polydrug Misuse – Dr Ian Telfer; Drug Detoxification – Carl Constantine; User Involvement – Ian Smith; Child Protection – Fiona Harpin; Homelessness and Asylum seekers – Dr Nat Wright. Contact Mark Birtwistle, Management Support Officer, SMMGP, 0161 905 8581 mark@smmgp2.demon.co.uk.

Thank you to the SMMGP readers who completed our satisfaction questionnaire. A summary of the findings are as follows: 2650 people on the mailing list with 217 replies as of end April which makes as the response over 8% The average for the usefulness of the newsletter to our readership is 4.60 out of 5 and the average for the presentation to our readership is 4.18 out of 5 There were 103 responses from GPs. Could those people who said they wished to write articles but who did not give their contact details, please contact us!

Hot Topic

The Royal College of General Practitioners (RCGP) has recently appointed a number of **GP Regional Clinical Leads** whose role will be to support local primary care organisations in developing capacity for drug misuse services in primary care. The Regional Clinical Lead posts have been created to support, direct, influence and contribute to the development of the Drugs Training Programme at regional level. The Leads will act at regionally as a point of contact in the provision of information, support and liaison for practitioners involved in or wishing to become involved in the care of drug users. The role includes sign posting towards appropriate training schemes, support networks, securing funding; co-ordination with national and local organisations and agencies; support to Certificate Mentors and GPs working in isolation; quality assurance. The Leads are accountable to the Chair of the NEAG (Dr Clare Gerada). The RCGP will be issuing a press release to announce the appointment of the Regional Leads in May to coincide with the 8th National Conference on the Management of Drug Users in Primary Care (Sheffield). For contact information on your local GP Regional Clinical Lead contact Mike Murnane at the RCGP mmurnane@rcgp.org.uk tel: 020 7173 6091

RCGP Guidelines for the appointment of General Practitioners with Special Interests (GPwSI) in the Delivery of Clinical Services April 2003 (Commissioned by the Department of Health)

The General Practitioner with Special Interest (GPwSI) should be seen as one option available to primary care organisations and must be part of a co-ordinated approach to treatment services and not seen merely as a pragmatic solution to dealing with waiting lists. A GPwSI service must not be seen as a substitute to a specialist service. Where a specialist provider is not in place then the PCO must ensure that a suitably trained practitioner fills this gap, rather than using the GPwSI as a substitute. Examples of core activities of a GPwSI service include clinical, education and liaison, service development and leadership. With regards to providing a clinical service for patients with drug misuse, these services can be offered either as part of an integrated general practice service with care being provided alongside other general medical services or as a stand-alone service. A stand alone service may be located within a dedicated drug misuse service within the NHS (primary or secondary care) or other provider and either targeted to a particular population or risk group (e.g. pregnant users, hard-to-reach groups,) or provided as part of a generic drug misuse service.

These guidelines are available in full at http://www.doh.gov.uk/pricare/gp-specialinterests/drugmisuse.pdf and can be read in conjunction with the Modernisation Agency's *Practitioners with Special Interests. A step by step guide to Setting Up a General Practitioner with Special Interest Service* April 2003, www.gpwsi.org

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